# HIV TESTING IN LOW PREVALENCE SETTINGS: CONSIDERATIONS FOR POST-AIDS EXCEPTIONALISM IN ATLANTIC CANADA. A POLICY DEBATE.

## Summary report from the Atlantic Policy Symposium Satellite Session held in Halifax, NS, on August 28th, 2013

## Introduction

On August 28th, 20 people gathered in Halifax, Nova Scotia, at Dalhousie University for a day-long workshop. The session brought together policy makers, people living with HIV/AIDS, researchers and service providers from across the Atlantic region to explore the potential implications of recent shifts toward the integration of HIV/AIDS policy, programming and funding with other sexually transmitted and blood borne infections (STBBIs), and the challenges and opportunities this creates for testing for HIV and other STBBIs. The workshop drew upon the diverse knowledge, values and experiences that participants brought to this complex issue.

The workshop was facilitated by Jacqueline Gahagan and Michelle Proctor-Simms. Dr. Gahagan is a Professor of Health Promotion at Dalhousie University and has worked in the area of HIV/AIDS/HCV primary and secondary prevention programming and policy responses for over two decades. Ms. Proctor-Simms is the Director of the Nova Scotia Advisory Commission on AIDS, an arms-length agency of the provincial government. As Director, she provides leadership and expertise in partnership with government departments, community-based organizations, and persons living with HIV/AIDS using a population health and social inclusion approach to address the recommended actions in the *Nova Scotia Strategy on HIV/AIDS* (2003).

## Objectives

The objectives of the workshop were to:

1. Explore practical ways to strategically link and/or integrate HIV/STBBI testing within formal health care and community-based service settings.
2. Discuss the positive and negative implications of reframing traditional approaches to HIV testing to an integrated HIV/STBBI testing model on service providers and on individuals/communities who are at a higher risk of HIV and other STBBIs.
3. Inform both national discussion and subsequent provincial initiatives to enhance access to HIV/STBBI testing in Atlantic Canada.

The anticipated outcomes were: 1) A summary report of the proceedings; and 2) Background for the future creation of a visual map of opportunities, barriers, and allies/actors as a way forward to enhance and integrate access to testing, care, treatment, and support in Atlantic Canada.

## Opening Address

The session began with a framing of the issue by Dr. Gahagan who first and foremost, drew our attention to the importance of considering the implications and consequences of dismantling a 30 year movement in the HIV/AIDS field as we move towards the integration of HIV with HCV, Tuberculosis, and other STBBIs. With this shift towards integration of services, supports, and funding, the question remains as to how an integrated approach will take into account the historical stigma associated with HIV.

To frame the discussion of potential policy implications, we drew from the new Public Health Agency of Canada (PHAC, 2012) publication, the "Human Immunodeficiency Virus (HIV) Screening and Testing Guide." The guide provides a number of recommendations to reduce identified barriers to testing including: Normalization of HIV testing and simplified risk assessment to reduce discomfort and stigma and increase the uptake of testing; make the consideration of an HIV test part of periodic routine medical care; and emphasize HIV as a chronic manageable condition and the benefits of treatment to reduce fear of HIV diagnosis. To view the complete guide, please visit this link: http://tinyurl.com/lzxdbpw. It was noted that one key area not addressed by the guide is the implications for HIV non-disclosure and criminalization. Nor does the guide address the issue of additional resources and infrastructure costs associated with the application of these recommendations and possible rise in testing uptake and diagnosis.

### Discussion:

**How will an integrated approach to HIV unfold in Federal and Provincial jurisdictions? In urban and rural communities? What is integration going to look like in a low prevalence setting?**

Discussion largely focused on the different levels of readiness for integration and the impact this could have on opportunities/barriers for testing. For example, Nova Scotia is the only province in Atlantic Canada with a provincial HIV/AIDS Strategy (currently under review). Participants also noted that Newfoundland and Labrador (NL) and Prince Edward Island (PEI) do not have access to anonymous testing. PEI also does not have an Infectious Disease Clinic; this means that residents have to travel to other jurisdictions to access these specialized services. In terms of integration, there appears to be more questions than answers with most left wondering how the provincial and federal levels of government will collaborate to help address these issues in the future. Most participants see the transition process as a time to focus on our strengths, and an opportunity to explore and try innovative approaches to prevention and partnership, and to leverage resources and funding.

**What are the concerns of the HIV sector regarding integration, and is the federal Government aware of these concerns?**

Communication between federal, provincial and community-based organizations will be critical to facilitate a smooth transition. Participants expressed concern over the lack of clarity related to whether or not there would be the necessary infrastructure in place to support the treatment of new infections due to the potential for increased testing uptake. Community-based organizations

expressed frustration over the evidence-base indicating social determinants of health as being predictors of vulnerability and risk of infection and, yet, they are not funded to do work within the social determinants framework.

**How has integration been approached in other jurisdictions or sectors, and what lessons can be learned?**

Discussion highlighted the need for guidance from those with experience with integration both within and outside of the HIV/AIDS sector. There is also a need to find a balance between drawing on existing work, and collaboration amongst the provinces and jurisdictions, while still recognizing the uniqueness of each province and the context-specificity of evidence moving forward.

## Jurisdictional Presentations: Implications and Strengths of an Integrated Approach for Atlantic Canada.

*Newfoundland & Labrador (Zack Marshall, PhD Candidate, Memorial University of Newfoundland & Labrador)*

Newfoundland and Labrador does not currently offer anonymous testing but there is interest in the province in discussing anonymous testing and also the rapid point of care (PoC) HIV test as part of a pilot project (currently 21 members). The Newfoundland and Labrador Centre for Applied Health Research conducted a scan regarding the types of PoC testing available for different health conditions in order to inform options for their local office. This reflects the national trend towards increasing access to testing in both rural and urban settings. In additional to access, a common barrier in low prevalence settings, especially rural settings, is privacy and confidentiality.

Opportunities: Strategically align with public issues that are on the radar, e.g., substance use, employment mobility; Participation in research to provide evidence e.g., employment migration and increased STI risk (AIRN proposal in review at CIHR); Newfoundland and Labrador is one of 3 Canadian hubs for a CIHR funded study of primary healthcare and HIV across Canada (NL hub is focused on 1) HIV and ethics in the context of primary care settings, and 2) health indicators and developing provincial cohort data). The Canadian Association for HIV Research (CAHR) conference will be in NL in May this year which is an opportunity to raise awareness and educate.

*New Brunswick (Margaret Dykeman, University of New Brunswick, retired Professor)*

New Brunswick has been offering anonymous testing since 1998. It is available in the seven health zones at the Sexual Health Centres and available to all regardless of age. New Brunswick has been offering anonymous HIV testing in correctional facilities since 2000 and has provided nominal and non-nominal HCV testing since 2001. However, provincial health clinics no longer see clients between the ages of 19 and 24. A number of clinics (provincial, private, non-profit) have taken on much of the burden of testing for this age group. Having testing offered by various organizations creates new challenges in reporting because databases cannot be linked due to privacy issues. It also creates challenges in that individuals may not know that services exist and not all health care providers have the same level of education regarding HIV testing.

Additional challenges: New Brunswick does not have an HIV/AIDS Strategy. Currently, there are no plans to address how to improve the numbers of persons being tested for HIV in the province, nor are there any plans to offer point of care testing. The province of New Brunswick has produced a document *A Chronic Disease Prevention and Management Framework* which is a

guide to all chronic disease management within the province. HIV/AIDS is one of the conditions that falls within this framework. However, there are no specific criteria listed within the framework for specific conditions; therefore, HIV/AIDS is only one of many. Additionally, due to the low numbers of persons seeking care within the province, few general practitioners (nurses, nurse practitioners, physicians) have regularly provided care for persons living with HIV/AIDS. People living with HIV seeking treatment must be seen in either Moncton or Saint John by specialists. With the move to more integration of services, practitioners will be challenged to improve their knowledge concerning all aspects of HIV/AIDS (testing, diagnosis and management). To date, there is no move to address how this will be accomplished.

*Prince Edward Island (Kathy Linton, Communicable Disease Program Coordinator, Chief Public Health Office, Department of Health & Wellness, PEI)*

Testing for HIV in PEI began in 1987. There are no specific policies regarding anonymous testing. There was a pseudo-coding system whereby patient would pick their own code or acronym but the General Practitioner knew the code and was able to identify the patient. Currently, people are seeking testing and treatment in Moncton or Halifax.

Challenges: No ID specialists currently practicing in PEI; Low prevalence of HIV with low public awareness; when people are screened for addictions or corrections, HIV testing is offered with 90% uptake rate

Opportunities: Public health act will be amended to reflect recommendations regarding consent (from where / whom); HIV screening routinely done for antenatal appointments

*Nova Scotia (Michelle Proctor-Simms, Director of the Nova Scotia Advisory Commission on AIDS)*

Nova Scotia has adhered to the traditional "voluntary counseling and testing model" based on the "3Cs," i.e., pre/post-test counseling; consent (specific, informed), and confidentiality. Health care providers are encouraged to offer HIV screening to all pregnant women using an "opt-in" approach. Testing is available in one of two ways: 1) Confidentially either *nominally* (since 1985) or *non-nominally* (since 1991); and 2) Anonymously (since 1994) available through the Halifax Sexual Health Center, AIDS Coalition of Cape Breton at three sites in Cape Breton, and by Pride Health in the CDHA. Given limited access to anonymous testing, "*Nova Scotia's Strategy on HIV/AIDS"* (2003) promoted "an integrated network of anonymous testing sites." Over the years, discussion has focused on how to provide equitable and affordable access to testing services tailored to provincial realities (e.g., small province, remote/rural, diverse population) based on the needs of the population or individuals being served.

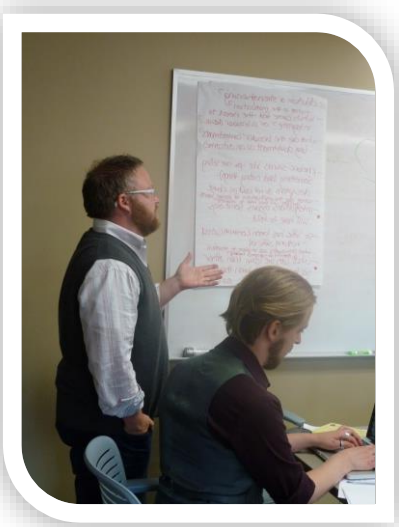
The new *HIV Screening and Testing Guide* by the PHAC provides a reference point for NS to re-examine its approach to testing as a *health equity* issue. It is important that discussion engage key parts of the health and social system (e.g., public health, primary care, acute and tertiary care) to ensure linkages across the continuum of prevention, care, treatment and support. A number of challenges need to be addressed: Enduring HIV stigma and discrimination (speaking to the need for the continuity of HIVAIDS-specific services within an integrated framework); limited access to culturally competent HIV and related services (including testing) for marginalized populations, rural communities, and ethno-racial populations; supports to help providers comply with PHAC guidelines; and to not devalue informed consent and the power of pre/post counseling to help address potential power imbalances and prevent new infections.

## Discussion following jurisdictional presentations

Participants discussed the importance of maintaining and strengthening the first voice of persons living with HIV/AIDS and Hepatitis C. "Care" should extend beyond the medical and should include the broader social determinants of health, and reflect and preserve quality of life of those affected. Integration may provide the opportunity to strengthen the connection between primary care and support specialists, but there needs to be more distinction between primary and secondary prevention. There is also a need to examine the costs-benefits associated with the increased identification of HIV (early detection, prevention, on-going treatment) versus later diagnosis (impacts on health, unknown status, etc.).

## Small group discussions with report-back

At the mid-point, the group broke into small group discussions each focused on one of four different questions. The purpose was to go deeper into the implications of integrated framework for HIV/STBBI particularly for testing; and to determine key messages for and/or realistic next steps at provincial, regional, and federal levels. The questions were:



1) What do we need to know about testing innovation (both the technology and capacity for its use) for combining HIV/STBBI?
2) What are the implications of integrated HIV/STBBI framework?
3) What are the natural contact points/synergies; allies; supporters for integrated HIV/STBBI testing?
4) What are &/or how to develop and/or address capacity issues in both traditional health & non-health care settings?

Key messages arising from the group discussions

**The need to:**

- Examine testing models (and existing models of integration outside of HIV) available and the costs associated with each model to inform future practice.
- Ensure that the necessary resources are in place to allow adequate follow up, treatment, and support. These resources need to be in a place that is accessible and well publicized.
- Ensure that all of the relevant stakeholders are at the table (e.g., include the administrators and policy makers) to establish stronger partnerships (regionally, provincially, and federally) and collaboration moving forward.
- Explore how prevention messaging will be impacted to include the broader mandates from integration (HIV and other STBBIs).
- Take time to reflect on the significance of this change and the end of AIDS exceptionalism (a 30 year movement), and consider the impact this will have on GIPA/MIPA principles and practices (and create safe guards against this and opportunities for other first voice participation).
- See this as a potential opportunity to alter public perception of HIV through broader interaction with other sectors (chronic illness).

- Examine how integration of HIV with other STBBIs will impact ethno-racial groups, priority population, and age groups (one size does not fit all).
- Increase communication and partnerships between policy makers, community-based organizations, academics and first voice persons to reduce duplication of services, reduce gaps in service, and facilitate information sharing.
- Explore, from the organizational level, what the changes to the PHAC's HIV/AIDS and HCV funding structure will mean for community-based organizations. Groups may need to revise mandates, and possibly re-name organizations to be more broad and inclusive. There is concern about of how to do this while maintaining a sense of identify and history. Organizations need time to process these changes and adequate funding to do needed consultation both provincially and regionally to reflect the unique challenges we face in our region.
- Develop a panel for the 2014 CAHR conference happening in St. John's, NL to discuss the transition to an integrated approach in the Atlantic Region from a public health perspective.

## Actionable 'next steps'

Three key, overarching issues were suggested as potential next steps for further discussion and action:

1. **Communication Needs** – Develop more effective communication approaches between government, community-based organizations and researchers, particularly in relation to communicating changes in testing policies and related guidelines.
2. **AIDS Exceptionalism** – Determine how to ensure the unique health and social issues associated with HIV/AIDS (stigma, discrimination, criminalization of non-disclosure, etc.) are addressed as policy and programming shift away from HIV as a stand-alone testing issue.
3. **Organizational Demands** – Develop both inter- and intra-provincial support mechanisms to ensure sufficient resources (both financial and personnel) are in place to respond to policy and programming changes at the AIDS Service Organization (ASO) level as their role expands beyond HIV/AIDS.

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